CareMedica

PATIENT INFORMATION

LAST NAME_____ FIRST NAME_____ MIDDLE INITIAL_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

*HOME PHONE NUMBER_____ *CELL PHONE NUMBER_____ *WORK PHONE NUMBER_____

BIRTH DATE_____ SOC SEC #_____ PREFERRED LANGUAGE_____

SEX **MALE** **FEMALE** MARITAL STATUS **SINGLE** **MARRIED** **DIVORCED** **WIDOWED**

RACE_____ETHNICITY:(***PLEASE CIRCLE ONE***)LATIN OR HISPANIC NON LATIN OR HISPANIC REFUSE TO REPORT

*PHARMACY OF CHOICE: _____ ADDRESS: _____ PHONE: _____

*LAB OF CHOICE: **(PLEASE CIRCLE ONE)** CLINICAL LAB QUEST OTHER: _____

EMPLOYER NAME _____ OCCUPATION_____

*EMERGENCY CONTACT NAME_____ RELATIONSHIP_____PHONE _____
(different than self) **(different than own phone #)**

ARE YOU INTERESTED IN ☐**MEDICALLY ASSISTED WEIGHT LOSS** ☐ **LASER HAIR REMOVAL** ☐ **BOTOX/ANTI-AGING TREATMENTS**

E-MAIL_____ ARE YOU INTERESTED IN RECEIVING E-MAILS? **YES** **NO**

INSURANCE INFORMATION

PRIMARY_____ ID#_____ GROUP #_____

SUBSCRIBERS NAME:_____ SOC SEC #_____ RELATIONSHIP_____

SECONDARY_____ ID#_____ GROUP #_____

SUBSCRIBERS NAME:_____ SOC SEC #_____ RELATIONSHIP_____

BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn over to collection for non-payment after 120 days, then the patient is responsible for the bill, the interest, and attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician for my charges.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the examination or treatment to insurance company in writing or by fax.

MEDICARE STATEMENT (if applicable): This claim will be submitted to Medicare for you by our office.Medicare may not cover some services, which the patient will be responsible to pay. Such identified services include yearly physicals. In addition, you will be responsible for your yearly Medicare deductible and coinsurance if you do not subscribe to supplemental policy.

SIGNATURE_____ **DATE**_____